DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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**CMS**
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

**Disabled and Elderly Health Programs Group**

NOV 0 6 2015

Mikki Stier, Medicaid Director
State of Iowa, Department of Human Services
100 Army Post Road
Des Moines, IA 50315

Dear Ms. Stier,

The Centers for Medicare and Medicaid Services (CMS) has been in discussions with you and your staff on Iowa's efforts to transition most Medicaid beneficiaries into mandatory managed care on January 1, 2016. We are currently reviewing the State's submission of the new Section 1915(b) managed care waiver, as well as the amendments to the State's Section 1915(c) waivers that would authorize this transition. Iowa, like all states, has the discretion to use a managed care delivery system to provide services to Medicaid beneficiaries. We appreciate your efforts to establish the new delivery system, conduct outreach to beneficiaries and providers, and your efforts to develop contingency plans to address issues that arise during the transition. However, CMS has significant concerns that the implementation timeframes for the transition to managed care may place access, continuity of care, and quality of care for beneficiaries at risk. We are also concerned about the extent to which managed care organizations (MCOs), providers, and Medicaid beneficiaries are prepared for the transition.
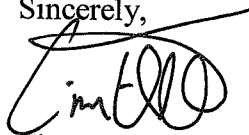
This letter confirms our recent conversations that in order for Iowa to address the above concerns, CMS will require the State to demonstrate the readiness of the state, MCOs, providers, and beneficiary support systems before CMS will approve the Section 1915(b) managed care waiver and allow the program to be implemented. To that end, on October 1, 2015, CMS provided a readiness-review document that outlines the criteria against which CMS will evaluate program readiness. We also provided a document on October 8, 2015 (attached as an appendix to this letter) that establishes a two-gate readiness-review process. The first readiness-review gate outlines eight conditions that are designed to ensure sufficient progress in the area of beneficiary communications and network adequacy. Meeting these conditions is essential to demonstrating overall readiness. For that reason, and to minimize any potential confusion on the part of beneficiaries and providers, CMS requests that the conditions of this gate be met before the state provides enrollment materials to beneficiaries. The state has provided materials to CMS on October 27, 2015 to substantiate readiness in these areas of the first gate. CMS is currently reviewing these materials, and committed to completing our review expeditiously.

The second gate review covers all areas of operational readiness at the state, plan, and provider levels. To determine whether the state has met these elements, CMS will review documentation from the State and conduct four days of on-site interviews. CMS' major concerns embodied in the gate 1 and gate 2 readiness-reviews, include:

- The extent to which the MCOs have hired and trained staff, as well as the extent to which they have developed and implemented necessary IT and support systems. Similarly, IT systems need to be operating properly in order for beneficiaries to receive services without inappropriate denials and ensuring continuity of care.

- The extent to which MCOs have adequate networks of contracted and credentialed providers, who are prepared to serve beneficiaries through the MCOs as required under 42 CFR 438.206 and 207. In order for the 1915(b) waiver to be approved, CMS will require each MCO to have a meaningful percentage (e.g., 80) of the current FFS (and Magellan) providers under contract and credentialed by the gate 2 readiness-reviews.

- The adequacy of the information, time, and support for enrollees to make an informed selection between the MCO that best meets their needs. This concern is particularly true for individuals receiving long-term services and supports (LTSS).

- The overall readiness of the State and MCOs to fully address the many administrative issues associated with a transition, especially issues related to beneficiaries' continuity of care such as grievances, appeals, care plans, case management, and utilization management criteria.

- Finally, CMS has been contacted by many individuals in the state expressing concern about the managed care transition, including the timeframes. For this reason, CMS will host several listening sessions in November for stakeholders and providers in order to better understand operational issues by those most affected from the transition. We invite the state to participate in those sessions with us.

CMS understands the state's interest in timely implementation of Iowa's new managed care program. We will continue working closely with the State on the readiness-review process and work with you on an approach to readiness that provide a smooth transition for beneficiaries, MCOs and providers, and support our shared goals of promoting high quality, coordinated health care to Medicaid beneficiaries. If you have any questions please contact James Golden of my staff at (410) 786-7111.

Sincerely,

Timothy Hill
Deputy Director
Center for Medicaid & CHIP Services

cc:     Vikki Wachino
        James Golden
        James Scott

## Iowa Health Care Initiative
## Readiness Gates

### Gate 1: CMS Criteria for Iowa Health Care Initiative Preliminary Readiness

CMS recommends that Iowa demonstrate that their planning and implementation efforts meet all of the following criteria in order to mail enrollment packets to beneficiaries. We think that demonstrating that these conditions are met will provide critical evidence that the State is on track to demonstrate full readiness through a Gate 2, CMS Criteria for Iowa Health Care Initiative Readiness Review.

- **Condition #1** - All MCOs have signed and fully executed contracts.

- **Condition #2** – Every MCO documents that it has contracted with and credentialed 50% of the current FFS providers in the following categories:

  o Primary care, adult and pediatric

  o OB/GYN

  o Five most common adult and pediatric specialty providers

  o Hospital

  o Pharmacy

  o LTSS providers

  o Behavioral providers, adult and pediatric (use Magellan's directory versus FFS for this provider type)

- **Condition #3** – Every MCO documents that it has hired at least 50% of its projected staff, especially customer service center staff.

- **Condition #4** – The State can provide a complete set of beneficiary enrollment materials for the mailings, including:

  o Each MCO's completed State-approved member handbook.

  o A list of the providers under contract and credentialed by each MCO and an explanation of how beneficiaries can learn about updates to the provider networks.

  o Information for the beneficiary about the MCO to which they have been auto-assigned and the procedures for changing the assignment.

  o A website maintained by either the State or Maximus that provides all of the enrollment materials and updates.

- o Information for beneficiaries about the ways that they can obtain enrollment assistance in person, over-the-phone, and through the internet.

- **Condition #5** – The enrollment broker, Maximus, has demonstrated readiness to serve beneficiaries, including:

    - o An operational enrollment website.

    - o Staff has call center scripts and a process to adapt the scripts to respond to unusual issues.

    - o Staff hired, in place, and trained to address beneficiaries' questions and issues.

    - o Staff has demonstrated training and knowledge of enrollment materials.

- **Condition #6** – The State provides CMS an initial readiness-review from Navigant that shows that the MCOs' activities and plans are likely to achieve a January 1 implementation date and the review does not contain any serious red flags.

- **Condition #7** – The State has a fully established and functioning ombudsman for individuals receiving LTSS.

- **Condition #8** – The State provides an update on the call center statistics related to calls on the initial beneficiary introductory letter. The State will need to describe if those statistics have been incorporated into the planning for customer service for the enrollment broker.

## Gate 2: CMS Criteria for Iowa Health Care Initiative Full Readiness

CMS will require that Iowa demonstrate that it meets all of the criteria in the following table in order to go live and begin operating a managed care program. It is possible that it may be able to demonstrate readiness for some populations, but not others (e.g., traditional Medicaid versus LTSS).

| Iowa HealthLink Program Implementation | | |
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| Functional Area | Operation Activities for Assessment | Action Steps |

| Iowa HealthLink Program Implementation | | |
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| **Functional Area** | **Operation Activities for Assessment** | **Action Steps** |
| 1. Administration | State<br><br>Resources for<br><br>Program<br><br>Operations<br><br>Interagency<br><br>Coordination<br><br>Stakeholder Engagement | State staffing plan for development, implementation, oversight and evaluation of Iowa Health Care Initiative, including:<br>• SMA staff assigned to initiative with job descriptions<br>• Customer service support for transition period (call center staffing and hours of operation)<br>• Coordinate daily calls in the transition period to compile call center statistics, reasons for calls, grievances/appeals, outreach activities, and any other implementation issues<br>• Care coordination/person-centered planning<br>• List of vendors State has contracted with that will aid with these activities and SOWs per contractor including plan for oversight of vendors<br>• Beneficiary support system personnel, phone line and data collection system in place<br>• Contracts with MCOs finalized<br>Plan administration:<br>• Hiring plan including job descriptions<br>• Building readiness including work space and accessibility<br>• System capacity to report member service calls and issues daily during the transition period<br>• Training schedule and materials prepared<br>• Contingency plans to pull from other health plans if they cannot hire enough for start date |
| 2. Enrollment-Related Functions | Enrollment and Disenrollment<br>Auto-assignment<br>Enrollment Broker<br>Choice Counseling and Beneficiary Support system<br>Eligibility and Enrollment Systems<br>Outreach<br>Enrollee Information<br>Marketing<br>Fraud and Abuse | State functions:<br>• Establishment of the Beneficiary Support System including enrollment broker prior to enrollment packets distributed<br>• Multiple modalities of choice counseling, if requested<br>• Auto-assignment algorithm developed/tested and programmed into the system<br>• Eligibility file transfer tested and running<br>• Contingency plans developed if beneficiaries are experiencing long call wait times<br>• Member materials developed and reviewed<br>• Member outreach schedule including ability for members to "meet" the plans<br>• Enrollment broker trained on for cause reasons for disenrollment |

| Iowa HealthLink Program Implementation | | |
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| | | Plan functions:<br>• Member materials developed and approved by the state<br>• Call center scripts developed and approved and staff trained on benefits<br>• Call center contingency plans developed<br>• Compliance officer hired and employee fraud prevention and notification materials signed |
| 3. Member Services | Member Handbook and Enrollee Information<br>MCO and State Customer Services<br>Outreach, Scheduling, and Transportation Enrollee Services and Supports | State functions:<br>• Oversight plans developed including reporting metrics and P&Ps<br>• Update and oversee website materials to ensure member information accurate<br>• Process to locate beneficiaries from whom mail was returned<br>• Oversee interface between plan and Enrollment broker to ensure up-to-date materials<br>• Transmit LTSS service plans to MCOs<br>Plan functions:<br>• Develop member handbook and get approved by the state<br>• Load LTSS service plans as authorizations<br>• Similar functions to enrollment and interface with state and enrollment broker<br>• P&Ps about member information and outreach<br>• Continuously updated provider directory for call center staff to reference |
| 4. Service Provision | Utilization Management<br>Service Delivery<br>Service Planning | State functions:<br>• State ride-alongs for LTSS, staffing and level of oversight<br>• Oversight plan<br>• Plan for tracking complaints/grievances for identifying trends<br>• Mechanisms state will use for assessing and identifying individuals with special health care needs and plan of how MCOs will implement appropriate plans of care for those consumers<br>Plan functions:<br>• P&Ps developed and staff trained<br>• Practice guidelines developed and approved for use by the State<br>• Inter-rater reliability tested<br>• Case management system functioning and staff trained on person-centered planning, system usability and level of detail in documentation necessary<br>• Interface with HCBS case managers to integrate into plan case management |

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| | | system<br>• Staff trained on all services available in the appropriate c waivers and community based supports resources |
| 5. Access | Provider Network Adequacy<br>Access and Availability<br>Access for People with Disabilities or Other Special Needs<br>MCO Contracts with Network Providers | State functions:<br>• State develops appropriate network adequacy and capacity standards for the plans to follow<br>• State reviews network adequacy reports per MCO including number of providers/facilities enrolled per geographic service area/county including all providers in the network<br>• State oversight of MCO-enrolled providers to ensure plans meet timely access to care standards pursuant to 42 CFR 438.206(c)<br>• State ensures all providers are enrolled in the Medicaid program<br>• Develop P&Ps for adequate oversight throughout the life of the contract<br>Plan functions:<br>• Plans do provider outreach to enroll providers and provide assistance through the credentialing process<br>• Plans provide in person assistance to the LTSS providers to train them on provider enrollment and credentialing practices as well as how to appropriately bill for claims in order to get paid timely<br>• Work with providers to ensure appropriate and accurate information collected during credentialing process to ensure provider directory is accurate and can include information like cultural competency, disability accessibility, and open panels<br>• P&Ps developed on provider credentialing process and ability for credentialing committee to meet more frequently, if necessary<br>• Ability to pull from corporate staff, if necessary, to credential and enroll providers more quickly<br>• Single case agreement process developed to handle out-of-network providers<br>• Outreach and education plan in place for all providers being handled out-of-network |
| 6. Continuity and Coordination of Care | Identifying and Assessing Health Care Needs<br>Primary and Specialty Care Coordination<br>Continuity of Care during the transition from FFS<br>Coordination with Carved-Out Services, Community Services, or Other State Programs/Agencies | State to develop continuity of care plan for all Medicaid enrollees and, in particular for HCBS recipients:<br>• Timeline for when each group can |

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| | | continue using current providers<br>• Provisions for permitting enrollees to retain their current HCBS providers and services, including all covered waiver services per HCBS program under current plans of care<br>• Transition and contingency plan for dispensing prescription drugs<br>• Process for overlap of case manager/care coordinators between external and internal case managers<br>Plan functions:<br>• Hire and train case managers in regular case management and in HCBS (even though people will be able to keep their case managers)<br>• Develop strategy to cull data to pull people into the category of benefiting from case management<br>• Ensure systems are in place to follow continuity of care procedures outlined in contract and by the state to ensure claims and services are not denied for the incorrect reasons<br>• P&Ps developed related to continuity of care |
| 7. Grievance, Appeal, and Fair Hearing Process | General Requirements<br>Enrollee Reporting of Grievances and Appeals<br>Handling of Grievances and Appeals<br>Monitoring of Grievances and Appeals | State functions:<br>• Develop resource plan for any state fair hearing issues, as well as a process to obtain necessary documentation<br>• Develop process for reporting and oversight of complaints, grievances and appeals to be able to track and trend issues within the plans<br>• Process to review a representative sample of LTSS service plans that have a reduction in services<br>Plan functions:<br>• Training of call center and other enrollee-facing staff to recognize when an issue is a grievance or appeal and when it should be referred to other staff at the plan to handle<br>• Tracking mechanism is in place for all staff to track when a grievance or appeal is filed with internal notifications for processing<br>• Develop state-specific reporting mechanism |
| 8. Critical Incident Monitoring and Reporting | Monitoring LTSS member health and welfare<br>Incident reporting and structural safeguards | State functions:<br>• Develop state standards for minimum monitoring periodicity, reporting of critical incidents, and procedures to |

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| | | address emergency situations<br>• Maintain central data on critical incidents, including nature of issue and resolution<br>• Train plans on mandatory reporting and other state laws and protective services for elders, people with disabilities, and children<br>Plan functions<br>• Train staff (call center and care coordination) on state requirements for monitoring health and welfare<br>• Maintain easily accessible public reporting system for critical incidents with P&P for investigation and disposition, including emergency institutional placement if needed |
| 9. Quality | Elements of State Quality Strategy<br>MCO Structural and Operational Standards<br>Quality Assessment and Performance Improvement<br>External Quality Reviews | State functions:<br>• Develop state quality strategy that incorporates all populations enrolled in managed care along with goals for the program<br>• Hire or re-scope current vendor for EQR activities<br>• Inclusion of LTSS quality measures and outcome goals into state-wide quality strategy<br>Plan functions:<br>• Quality management plan developed and staff trained on the management plan<br>• P&Ps created related to the quality systems in place<br>• Performance Improvement projects developed and committees set up to measure any improvements |
| 10. Systems | General MMIS Operations<br>Payment Systems<br>Eligibility and Enrollment<br>Third Party Liability (TPL)<br>MCO information Systems, including Provider Payment Systems | See finance and encounter data.<br>Provide status of system readiness based on testing |
| 11. Program Integrity | State Administrative Structure, Communication, and Reporting<br>Finance, Data, and Systems Assurance<br>General Contractor Oversight and Reporting<br>Provider Screening and Enrollment | State functions:<br>• Develop reporting plans for any program integrity issues such as payment to excluded providers, credentialing processes to ensure excluded providers not permitted in network, collection of overpayments or any other program integrity issue<br>• Develop functions at the MFCU to oversee managed care issues as compared to FFS issues<br>Plan functions: |

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| | | • Develop systems to track and collect program integrity issues<br>• Hire compliance officer and train staff on identification of fraud and abuse<br>• Develop reporting structure for the State when issues are identified<br>• Develop plan to report any collection of overpayment to the systems process |
| 12. Encounter Data | Encounter Data System Design<br>Standards for Collection of Encounter Data<br>Using the Encounter Data System to Monitor Managed Care performance | State functions:<br>• Prepare MMIS or other data warehouse to be able to collect MCO encounter data<br>• Remove unnecessary edits from data warehouse so state can collect all encounter data<br>• Develop plan for review of encounter data upon submission so the state can use it for future rate setting purposes<br>• Test the encounter data submission system<br>Plan functions:<br>• Test file transfers with the state and remedy any issues<br>• Develop P&Ps about timeliness and frequency of data transfers<br>• Develop any contracts with subcontractors about encounter data submission so it complies with how the state will need to collect it<br>• Develop testing plan to prevent duplicates and other erroneous encounters being sent to the state |
| 13. Finance | General Financial Oversight Payments to Providers<br>Third Party Liability (TPL) and Coordination of Benefits | State functions:<br>• Oversight of plans to ensure they are recovering funding when appropriate and ensure that gets carried through to the encounter data<br>• Ability to receive prescription drug utilization data on quarterly basis from MCOs in order to pursue drug rebates from manufacturers and to return portion of federal share<br>• Review plan reporting to ensure timely payment of all clean claims and all claims in general<br>• Implement contingency plans if providers are not able to get paid timely or if out-of-network providers refuse to bill plans<br>Plan functions:<br>• Test claims payment functions and have working P&Ps on timely payment of claims<br>• Train staff on other areas of TPL to ensure appropriate billing of third parties |

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| | | • Provider TA on filing a clean claim – especially for LTSS providers<br>• Develop system edits for specific benefits including which services need prior authorization<br>• Create any system edits necessary to account for claims from LTSS providers which may have unique service codes or other pertinent factors<br>• If necessary, ensure the ability of LTSS providers to bill with paper claims if systems capabilities are not as advanced |